THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from DXM

Dextromethorphan: cough syrups, gel caps, and tablets ("robo," "robotripping," "Triple C," "Skittles"). A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. THE MOST DANGEROUS THING ABOUT DXM IS OFTEN WHAT ELSE IS IN THE BOTTLE.** Combination products can carry acetaminophen (liver failure that stays silent for 24 to 72 hours), chlorpheniramine (Coricidin "Triple C": seizures, arrhythmia, overheating, deaths), or decongestants (high blood pressure, dangerous heart rhythms). **If you may have taken a lot of acetaminophen, call Poison Control (1-800-222-1222) or go to an emergency department now, without waiting for symptoms.**
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> **DXM plus an SSRI, SNRI, MAOI, tramadol, or linezolid can cause fatal serotonin syndrome** (agitation, confusion, racing heart, high blood pressure, twitching or rigid muscles, high temperature): call 911. Call 911 too for extreme confusion, very hot skin with no sweating, very slow or stopped breathing, or a seizure, and tell responders "DXM, dextromethorphan." A CYP2D6 poor metabolizer can get serotonin syndrome at much lower amounts.
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> The mood crash after stopping can be severe. Crisis: call or text 988 · Crisis Text Line: text HOME to 741741 · Teen Line: 1-800-852-8336 · SAMHSA: 1-800-662-4357

1. Before you start

This is a route through the Recovery Kernel for people whose use of DXM has become a problem, and for the family, friends, and clinicians around them. The Kernel calls it the most clinically invisible significant substance problem in the series: an $8 bottle, no prescription, no age check in many places, often bought by teenagers and young adults who are isolated, depressed, or untreated for something else, and dismissed as "just cough syrup." This guide takes it seriously. The Kernel's frame is that DXM is pharmacologically unusual: in most people a liver enzyme (CYP2D6) turns it into dextrorphan, a potent NMDA blocker much like ketamine, while DXM itself acts on sigma-1 receptors and blocks the serotonin transporter, with a weak opioid effect at very high amounts. Which of these you mostly experienced depends on your genes and your other medications. Six rules follow.

- **Product first.** Find out exactly what you used, because the co-ingredient may be the real danger.
- **Check every medication.** DXM with serotonergic drugs is the most common serious and entirely preventable medical complication.
- **Know your CYP2D6.** It decides which compound reached your brain, and antidepressants such as fluoxetine and paroxetine can turn a normal metabolizer into an effective poor one.

- **Recovery is mostly internal.** The supply is at every pharmacy, so the route builds an interrupt and a treatment plan for what DXM was solving, not only a barrier.
- **Treat what it was treating.** Depression, ADHD, social anxiety, and trauma are the usual answers, and they need their own care.
- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapter is Chapter 24 (How to Recover from DXM), which builds on the ketamine (Ch. 23), MDMA (Ch. 14), and LSD (Ch. 26) chapters. Section numbers (§) refer to sections inside those chapters.

> **If the DXM was prescribed.** Some prescription medicines contain dextromethorphan, for example an antidepressant that combines it with bupropion, and a DXM and quinidine product. This guide is about use outside a prescription. Never stop or change a prescribed medicine on your own, and tell your prescriber about any non-prescribed DXM, since it changes the interaction risks. (This note is added by this guide and is not in the Kernel.)

> **A note on protocol numbers.** Supplemental Chapter 24 cites Compendium protocols by number, and some numbers do not match the Compendium as printed. It calls Protocol 13 "The Physician Conversation" (printed: The Pharma Trap), Protocol 05 the environment and digital-redesign protocol (printed: Digital Detox), Protocol 04 "Dharma Recovery" (printed: Meeting Alternatives), Protocol 03 "exercise" (printed: Sonic Architecture; exercise is Protocol 19), and Protocol 20 the identity protocol (printed: Mapping the Terrain). It also cites a "C-37 principle" (the Compendium prints Protocol 37, Substance Masking Analysis) and a "psychedelic/dissociative sonic protocol" without a number. This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
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> For DXM, watch for taking more to “reach the next plateau” — self-assessment is exactly what the drug impairs, and a co-ingredient like acetaminophen escalates with every added dose.
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> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first year. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: which product, what else was in it, medication interactions, emergency signs.	Supp. Ch. 24 §0 Main Book, Quick-Start Step 1 Compendium P01
1	Days 0–7	Liver and safety assessment. Ride out the NMDA rebound and the mood crash.	Supp. Ch. 24 §3.2, §4.2, §7, §8.1
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3
3	Weeks 1–4	Order 30× whole-genome sequencing. CYP2D6 is the priority.	Supp. Ch. 5 Step 1 Supp. Ch. 24 §2 Compendium P06
4	Weeks 2–6	Resolve your profile. Work out which function DXM served.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 24 §1.2, §1.4, §2
5	Day 1 to Month 6	Build the foundation: methylation, NMDA support, liver, serotonin (after a wait), sleep.	Supp. Ch. 24 §4 Supp. Ch. 5 Phase One Compendium P07, P09, P17
6	Weeks 1–12, then ongoing	The pharmacy problem. Learn the trigger map and the 10-minute rule.	Supp. Ch. 24 §5 Compendium P05, P08, P21
7	Weeks 2–12	Treat the underlying condition. Have the physician conversation in clinical language.	Supp. Ch. 24 §4.6, §8 Supp. Ch. 39 Compendium P13
8	If present	Persistent visual phenomena (HPPD-like) and how to handle them.	Supp. Ch. 24 §4.5 Supp. Ch. 26 §4
9	Months 1–12+	Build natural access to the states DXM provided. Adolescent and family architecture.	Supp. Ch. 24 §6 Supp. Ch. 23 §6; Ch. 26 §6 C-28; Compendium P19
10	Months 3+, Year 1 to 10	Identity, the invisible problem, and the long game.	Supp. Ch. 24 §7, §8 Supp. Ch. 42, 43, 44 Compendium C-28, P24, P25

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Look at the label of what you used. The Kernel's product table: acetaminophen (NyQuil, DayQuil, many syrups) is silently toxic to the liver at misuse amounts, and damage becomes irreversible if untreated. Chlorpheniramine, an antihistamine in Coricidin Cough & Cold ("Triple C"), is the most dangerous commonly misused DXM product, and the Kernel says the chlorpheniramine, not the DXM, is the main killer: it causes confusion, hallucinations, fast heart rate, overheating, seizures, and arrhythmia, and needs hospital care. Guaifenesin causes severe vomiting, which is dangerous if you are sedated. Decongestants (pseudoephedrine, phenylephrine) add high blood pressure and heart-rhythm risk. Products that contain DXM only (Delsym, plain gel caps) avoid these co-ingredient hazards, which the Kernel notes is a harm-reduction fact, not an endorsement.

Then medications. DXM blocks the serotonin transporter, so it adds to SSRIs, SNRIs, MAOIs (including high-dose St. John's wort), tramadol, and linezolid. Paroxetine and fluoxetine are also strong CYP2D6 blockers, so DXM builds up further, and the Kernel calls DXM with Prozac or Paxil one of the highest-probability serotonin syndrome combinations in over-the-counter use. Emergencies at high amounts: delirium you cannot talk someone out of (the Kernel's "fourth plateau"), overheating (which it names as the most likely cause of death at very high amounts), respiratory depression (naloxone may partly help, but it is not a fix), and seizure. Move the person away from traffic, heights, and water, keep the room calm, cool them if hot, and call 911.

> **A caution this guide adds.** The Kernel suggests taking oral NAC promptly after significant acetaminophen exposure. Oral supplements are not a treatment for a possible acetaminophen overdose, and treatment depends on how much and when. Call Poison Control (1-800-222-1222 in the US) or go to an emergency department, and take the label with you.

Turn to: Supp. Ch. 24 §0 (product toxicity; the serotonin syndrome interaction; high-dose emergency recognition). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Liver, safety, and the first week (Days 0–7)

The Kernel says the only time-urgent recovery item for DXM is the liver check if acetaminophen was involved: AST, ALT, bilirubin, and GGT in the first week and again at about three months, with hepatology referral if enzymes are significantly raised. If decongestants were involved, add an ECG and blood pressure check. DXM has no seizure-risk withdrawal like alcohol or benzodiazepines and no opioid-style withdrawal illness. What follows is the ketamine and psychedelic territory: in the first day, anxiety, mental overdrive, sensory sensitivity, a mood crash, and disrupted sleep from the NMDA rebound; over days 1 to 7, often significant depression as the artificial lift clears (the Kernel calls it the most common relapse driver in this window), fog, irritability, and sometimes visual phenomena. Keep the space low-stimulation, avoid stimulants, and use the breathing practice.

One rule for the first days: the Kernel says to wait 3 to 5 days after the last DXM before starting 5-HTP, because residual serotonin-transporter blockade plus a serotonin precursor risks serotonin syndrome. Never combine 5-HTP with an SSRI, SNRI, or MAOI.

Turn to: Supp. Ch. 24 §3.2 (the withdrawal and aftermath timeline), §4.2 (liver support for acetaminophen co-exposure), §7 (the protocol map), §8.1 (medical priorities). Compendium Protocol 01, Emergency Triage.

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are settled. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease, which matters here if the liver was hit.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT), Ch. 4 (CYP450, the chapter on CYP2D6), Ch. 5 (When Systems Collide) → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 9 and 10. Appendix A (which includes the interaction matrix) and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning). The Kernel has no DXM case study. The nearest are Case 09 (ketamine, an NMDA and trauma profile) and Case 06 (MDMA, a serotonin profile). Supp. Ch. 23 (Ketamine), Ch. 14 (MDMA), and Ch. 26 (LSD), which Chapter 24 tells you apply. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP calls. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

The Kernel calls DXM the most genetically variable substance in the series. **CYP2D6** is the defining gene, and it matters for future prescriptions too. Next come **SLC6A4** (short/short carriers feel the serotonin effect more and carry more serotonin syndrome risk), **HTR2A** (intensity of the psychedelic-adjacent effects and HPPD risk), **COMT** (Met/Met is overrepresented in escape from anxiety), **MTHFR**, and **DRD4/DAT1** (the ADHD-linked variants, since many people with problematic DXM use have untreated ADHD). Until results arrive: did DXM hit much harder than for others at the same amount; was it mostly warmth and mood lift more than dissociation (a poor-metabolizer pattern); did you ever have a serotonin-syndrome-like reaction; did small amounts help you focus; did you develop visual disturbances?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 24 §2 (the DNA testing panel for DXM recovery; phenotyping without testing). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your profile (Weeks 2–6)

Write your profile down and carry key results on a card. The Kernel says CYP2D6 does not just change how strong DXM is, it changes which substance you experienced.

If your result is...	What changes	Source
CYP2D6 normal metabolizer	DXM converts efficiently to dextrorphan, so the experience was mostly dissociative (NMDA blockade, like ketamine). Recovery leans on the ketamine framework, with serotonin rebuilding second.	Supp. Ch. 24 §1.2
CYP2D6 poor metabolizer	DXM itself accumulates: more serotonin transporter blockade and sigma-1 effect, less dissociation, and much higher serotonin syndrome risk. Never combine DXM with any serotonergic medication.	Supp. Ch. 24 §1.2, §2
CYP2D6 ultrarapid	Faster conversion to dextrorphan: more intense, quicker dissociation. Bupropion, fluoxetine, or paroxetine can make an ultrarapid metabolizer act like a poor one.	Supp. Ch. 24 §1.2
On fluoxetine or paroxetine	These are SSRIs and CYP2D6 blockers, so they turn a normal metabolizer into an effective poor one and add their own serotonin blockade. Tell your prescriber about any DXM use.	Supp. Ch. 24 §0.2, §1.2
SLC6A4 short/short	A stronger serotonin effect, and both the wanted mood lift and the syndrome risk are amplified. With CYP2D6 poor metabolizer status, this is the most extreme risk profile.	Supp. Ch. 24 §2
COMT Met/Met (Sage)	DXM gave escape from anxiety. Anxiety management is the primary target alongside NMDA normalization.	Supp. Ch. 24 §2
MTHFR variants	A methylation deficit may have driven the depression DXM lifted. 5-MTHF often improves mood early and should be assessed before an SSRI trial.	Supp. Ch. 24 §2, §4.6; Main Book Ch. 2
DRD4 7-repeat / DAT1 10-repeat	ADHD-linked. DXM may have given a paradoxical focus at lower amounts. Ask for an ADHD evaluation.	Supp. Ch. 24 §1.4, §2
HTR2A high-expression	More intense psychedelic-adjacent effects at higher amounts and a likelier HPPD risk. See Step 8.	Supp. Ch. 24 §2, §4.5

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 24 §1.4 (what DXM was providing) and §2. Main Book Ch. 5 and Appendix A.

Step 5 — Build the foundation (Day 1 to Month 6)

The Kernel says recovery rebuilds three systems on a methylation base: the NMDA and glutamate system (like ketamine recovery), the serotonin system (like MDMA recovery, but milder), and the liver if acetaminophen was involved. Methylation: 5-MTHF, methylcobalamin, active B6, and magnesium glycinate, which it calls the most important supplement for the NMDA side and starts on day 1. NMDA support: NAC (serving both glutamate balance and liver protection), magnesium, L-theanine, glycine, and omega-3. Serotonin: 5-HTP or tryptophan (not both), only after the 3 to 5 day wait and never with serotonergic drugs, plus inositol and EPA-rich omega-3. Liver support after significant acetaminophen exposure runs for weeks under a clinician's guidance, with milk thistle, alpha-lipoic acid, and NAC as the Kernel's options. Sleep: magnesium, glycine, L-theanine, and melatonin, and ambient music that is not tied to using, since the auditory memory can trigger craving. The dose tables are in the chapter and belong with your prescriber. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape). The peptide layer in Supp. Ch. 24 §4.8 is not a self-start step.

Turn to: Supp. Ch. 24 §4.1 (methylation), §4.2 (liver support), §4.3 (NMDA system normalization), §4.4 (serotonin reconstruction), §4.7 (sleep), §4.8 (peptides, physician only). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 07 (Neuroplasticity), Protocol 09 (The Gut-Brain Axis), Protocol 17 (The Nightly Restoration), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — The pharmacy problem (Weeks 1–12, then ongoing)

The Kernel says DXM has the shortest path from craving to use of anything in the series: ten minutes and $8 at any pharmacy, gas station, or grocery store. So recovery has to be substantially internal. Five triggers: passing a pharmacy or cold-and-flu aisle; a depression dip (the most reliable craving trigger); isolation with nothing to do; an anxiety spike, especially social; and online DXM communities and trip reports. The response: take routes that avoid pharmacies early on, do not enter the cough-and-cold aisle, bring a trusted person for pharmacy errands, ask about a flag on your account where a chain offers it, and block DXM forums for now.

The 10-minute rule and interrupt: when a craving fires, stop walking toward the supply and do not decide for 10 minutes; five cycles of 4-7-8 breathing; your NAC and magnesium; name the underlying state (depression, anxiety, boredom, ADHD); change your route or environment; contact someone; and turn to a natural alternative (non-sleep deep rest, meditation, vigorous exercise, absorbing music). The Kernel notes some states restrict DXM sales or require ID, and some pharmacy chains track purchases, so check what applies where you live.

Turn to: Supp. Ch. 24 §3.1 (what makes DXM recovery different), §5 (the DXM craving: the trigger map and the 10-minute interrupt), and §8.3 (purchasing restrictions and resources). Compendium Protocol 05 (Digital Detox), Protocol 08 (Social Environment), Protocol 21 (Reading the Collapse).

Step 7 — Treat the underlying condition (Weeks 2–12)

The Kernel's principle: DXM was a solution, so recovery means finding the actual problem. Depression is often the main driver: assess 5-MTHF first (methylation-variant depression is common and can respond without an SSRI), and see a psychiatrist if it is still clinical at about six weeks with the foundation in place. An SSRI can be appropriate but only after DXM has stopped completely. Undiagnosed ADHD is significantly over-represented, so ask for an evaluation early: the Kernel points to non-stimulant options such as atomoxetine, guanfacine, and viloxazine where stimulant misuse is a concern. Social anxiety, which the drug made bearable, responds to CBT, graded exposure, and buspirone or an SSRI after cessation. Trauma needs EMDR, CPT, or another trauma-specific treatment.

How to be taken seriously: "I've been drinking a lot of cough syrup" tends to get dismissed. The Kernel suggests naming it clinically: the substance (dextromethorphan) and product, how often and how much, the symptoms you have now (rebound anxiety, mood crash, visual phenomena, fog), your concern about liver damage from acetaminophen and a request for liver tests, a request for CYP2D6 testing, and your suspicion that depression, ADHD, or anxiety was driving the use. There is no MAT for DXM and there are no DXM-specific clinical guidelines, so you may need to advocate.

Turn to: Supp. Ch. 24 §4.6 (underlying condition treatment), §8.1 (medical priorities), and §8.2 (having the physician conversation). Supp. Ch. 39 (Complex Trauma and the Substance Connection). Compendium Protocol 13 (The Pharma Trap).

Step 8 — Persistent visual phenomena (if present)

Heavy DXM use at the higher plateaus can produce persisting visual phenomena like those seen with ketamine and psychedelics (HPPD). The Kernel's advice: stop DXM completely, since the receptors cannot recover under continued stimulation; stop cannabis, its most reliably reported aggravator; use the antioxidant and sleep-and-anxiety approach from the LSD chapter; and get a neurological and psychiatric evaluation if the phenomena are persistent and impairing at four or more weeks. It says short-term clonazepam and lamotrigine have evidence for HPPD in specialist hands, and that DXM-associated HPPD is generally milder than psychedelic HPPD, with most cases resolving over weeks to months. It also advises against SSRI monotherapy for visual phenomena, while elsewhere saying an SSRI is fine once DXM has stopped, so this is a psychiatrist's call. Any loss of reality testing, or voices or persecutory beliefs, needs urgent evaluation.

Turn to: Supp. Ch. 24 §4.5 (HPPD management from heavy DXM use). Supp. Ch. 26 §4 (HPPD: what it is and is not; management).

Step 9 — Build natural access to the states DXM provided (Months 1–12+)

The Kernel says the architecture has to match the function DXM served. For dissociative escape, the ketamine approach: meditation (at least 20 minutes daily, built up), non-sleep deep rest, and the Kernel's other practices for quieting the mind. For mood elevation and emotional warmth: vigorous daily exercise, scheduled time with safe people, laughter, and music. For social anxiety: a CBT-based program with graded exposure, and community. For consciousness exploration: one contemplative tradition practiced systematically, with a map and a community. For focus: ADHD treatment, daily exercise, and a structured environment. It calls the treatment of ADHD the simplest and most commonly missed step.

For adolescents and young adults, the Kernel adds a specific architecture: recovery is partly a first construction of identity, not a return to a prior self; the family system is part of the environment, and family members who understand that this is not "just cough syrup" help; school is affected by fog and unmanaged ADHD, so accommodations and counselor support are recovery tools; the peer group needs renegotiating, and finding peers through sport, arts, or teams is the main social step; and some young people used the drug to get through questions about sexuality, identity, family stress, and meaning without adult frameworks, so recovery includes building those frameworks in therapy and community.

> **A caution this guide adds (not in the Kernel).** Hyperventilation-based breathwork can provoke panic or dissociation in people with a psychosis history, seizure history, heart conditions, or persistent perceptual disturbances. If any of those applies, ask your clinician before trying it, and start with slow breathing, non-sleep deep rest, and meditation.

Turn to: Supp. Ch. 24 §6 (porting the addiction; the natural architecture; the adolescent-specific architecture). Supp. Ch. 23 §6 and Supp. Ch. 26 §6, which §6 tells you apply. Centurian Paper C-28 (The Recast). Compendium Protocol 04 (Meeting Alternatives, which the Kernel calls Dharma Recovery), Protocol 19 (The Body in Motion), Protocol 29 (The Peacetime Paradox).

Step 10 — Identity and the long game (Months 3+, Year 1 to Year 10)

The Kernel's closing view: the cough syrup told you the truth, that your nervous system needed something, and recovery is finding out what that something actually is. For young people this is often a first construction of identity, and the contemplative tradition, the creative practice, and the genuine community are not replacements for DXM but the actual project it was deferring. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Navigation after the first year shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

Turn to: Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Compendium Protocol 24 (Returning to Work), Protocol 25 (The Open Door), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table. The Kernel's DXM timeline ends at about six months, so later years are projection.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and liver	Liver check; no serotonin mixing	Medication review; SSRI caution [1]	Cough-and-cold products checked	DXM + serotonin meds: never mix [7]
Biology and genome	CYP2D6 first; SLC6A4, MTHFR	Retest labs; step stack to upkeep [2]	Prescriber card: CYP2D6 status	Re-check with new meds and age
Access and cues	Pharmacy routes; 10-minute rule	Cues fainter, less pull	Triggers shift: low mood, alone [5]	Same plan, rehearsed
Underlying condition	Depression, ADHD, anxiety assessed	Treatment holds; no DXM needed [3]	Mood, focus plan, clinician-led	Annual review; meds cross-checked
NMDA and serotonin repair	NAC, magnesium; 5-HTP after a wait	Systems recovered; stack at upkeep	Maintenance, sleep habits	Stress plan, sleep habits
Natural access practice	Daily NSDR, sit; exercise, people	Practice deepens; tradition chosen [4]	Deepening; teacher, retreat	Practice as a way of life
Identity and Manning	Identity work, first draft	Transplant; school or work	Manning: peer and family guide [6]	Mentor or run a group

The seven shifts

1. **Year 3, medications are reviewed, with SSRI caution.** If you were started on an antidepressant during recovery, the Kernel's rules still apply: DXM and serotonergic drugs do not mix, and 5-HTP does not mix with them either (Supp. Ch. 24 §0.2, §4.4). Review each medication with the standard in Compendium Protocol 13, and remember that some cough and cold products contain DXM.
2. **Year 3, the stack moves from building to upkeep.** The Kernel says NMDA, serotonin, and sigma-1 systems are substantially recovered within months, with HPPD resolved for most (Supp. Ch. 24 §3.2). Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, treatment holds and DXM is not needed.** The Kernel says without the underlying-condition track, recovery is "holding a gap without filling it" (Supp. Ch. 24 §7). By year 3 the treatment for depression, ADHD, or anxiety should be doing that job, with the plan reviewed by your clinician.

4. **Year 3, the practice deepens.** The Kernel points to one contemplative tradition practiced systematically as the durable version of what DXM was exploring (Supp. Ch. 24 §6). By year 3 that tradition, or a comparable practice, should be chosen and steady.
5. **Year 5, triggers shift to low mood and being alone.** The Kernel names the depression dip and isolation as the most reliable triggers (Supp. Ch. 24 §5). As pharmacy cues fade, what remains is the state that drove the use. Keep the mood plan current and your people close. This shift is extrapolation.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). This is extrapolation: peer support for young people the Kernel says clinics rarely serve, and guidance for families who have been told it is "just cough syrup."
7. **Year 10, never mix DXM with serotonergic medication, and check every cold product.** Serotonin syndrome is described by the Kernel as entirely preventable (Supp. Ch. 24 §0.2), CYP2D6 status affects many future prescriptions, and DXM sits in many cough and cold products. Keep your CYP2D6 result on your card.

What is sourced and what is extrapolated. *Shifts 3, 4, and 7 rest directly on Kernel text. Shifts 1 and 2 apply Kernel rules at a timing chosen for this guide. Shifts 5 and 6 are extrapolations. The Kernel's detailed DXM timeline ends at about six months.*

5. What outcome to expect

The short version

The Kernel has no DXM case study and gives no 12-month percentages, so this section is qualitative and does not make up numbers. If you do the route above, with the product and liver checks first, medication interactions handled, the foundation built, the pharmacy problem planned for, and the underlying condition treated, this is what the Kernel supports:

- **Days 1 to 7 are the crash.** NMDA rebound, mood crash, fog, and sleep disruption, with depression as the main relapse driver. It passes, but do not go through it alone.
- **Weeks 2 to 8 bring gradual, uneven improvement,** with the underlying depression, ADHD, or anxiety reasserting itself without the chemical buffer, so treatment begins here.
- **By months 1 to 6, substantial recovery.** NMDA function substantially recovers, serotonin and sigma-1 systems rebuild, HPPD has resolved for most people, and the states DXM gave begin to be reachable through practice.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk. It says relapse risk is highest at low-barrier moments (a pharmacy visit, a depression dip), and that recovery without the underlying-condition track is incomplete.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Safety and liver check	Days 0–7	Product identified. Liver enzymes checked if acetaminophen was involved. Serotonergic medications reviewed. ECG if decongestants.	Supp. Ch. 24 §§0, 4.2, 8.1	Clinical fact
The first day	Hours 0–24	NMDA rebound: anxiety, overdrive, sensory sensitivity, mood crash. Low stimulation, NAC and magnesium, breathing.	Supp. Ch. 24 §3.2	Clinical timeline
The crash	Days 1–7	Depression (often significant), fog, disrupted sleep, possible visual phenomena. 5-HTP only after day 3–5.	Supp. Ch. 24 §3.2	Clinical timeline
Reassertion	Weeks 2–8	Systems recovering with variability. Underlying depression, ADHD, or anxiety reasserting. Treatment begins. HPPD diminishing or being assessed.	Supp. Ch. 24 §3.2	Kernel projection
Substantial recovery	Months 1–6	NMDA substantially recovered. Serotonin and sigma-1 systems rebuilt. HPPD resolved for most. Meaning beginning to be reachable through practice.	Supp. Ch. 24 §3.2	Kernel projection
Liver follow-up	About month 3	Repeat liver tests if there was acetaminophen exposure.	Supp. Ch. 24 §8.1	Kernel projection
Deep-root reversal	2–5+ years (heavy long-term use)	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Treatment for the underlying condition steady. Practice and service. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's 12-month numbers: none for DXM

The Kernel has no DXM case study and gives no DXM-specific projection, so there is no 12-month table here, and this guide will not make one up. The nearest profiles in Supplemental Chapter 2 concern other substances: Case 09 (ketamine) is an NMDA and trauma profile, and Case 06 (MDMA) is a serotonin-system profile. Neither is a prediction for DXM. What the Kernel does offer is the aftermath timeline above.

What changes the outcome

- **Not knowing what was in the product.** Acetaminophen, chlorpheniramine, and decongestants are the danger. Get the liver check.
- **Mixing with serotonergic medication,** including paroxetine or fluoxetine, which also block CYP2D6, or starting 5-HTP too early.
- **Ignoring CYP2D6.** It explains the experience and the risk, and matters for future prescriptions.

- **Leaving the pharmacy route unchanged,** or going through the first weeks alone.
- **A recovery with no treatment for the underlying condition.** The Kernel says this holds a gap without filling it.
- **Untreated ADHD or depression,** the two most common drivers.
- **Cannabis while visual phenomena persist.**
- **Being dismissed and giving up.** The Kernel says to name the substance and symptoms clinically and ask for specific tests.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). It is also a medical event: check the product, check your medications, and call 911 for emergency signs.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the product hazards (acetaminophen liver toxicity, chlorpheniramine toxicity, decongestant heart effects), serotonin syndrome with serotonergic drugs, and the CYP2D6 effect on DXM are well established clinically. The Kernel's claim that overheating is the most likely cause of death at very high amounts, its HPPD prevalence and medication notes, and its statement that DXM-HPPD is generally milder are limited evidence. The supplement stack, the peptide layer, the natural-access comparisons, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts. The Kernel's purchase-restriction statements vary by state and chain, so check locally.

Take these to your clinician

- The exact products you used (brand and label), how much and how often, and any other substances, including alcohol and cannabis, so liver, heart, and interaction risks can be judged.
- Every medication and supplement you take, especially any SSRI, SNRI, MAOI, tramadol, or bupropion, and before any 5-HTP.
- A request for liver tests (and an ECG if decongestants were involved), and for CYP2D6 testing.
- Your symptoms in specific terms (rebound anxiety, mood crash, fog, visual phenomena), and whether depression, ADHD, social anxiety, or trauma was driving the use, so evaluation and treatment can start.
- If you are a young person or a parent: a request for an adolescent-informed clinician or counselor, school support, and family involvement where it is safe.